

Express Contraceptive Visit

Name _____ Date of birth _____

First day of last menstrual period _____ Date of last intercourse _____

Birth control method you are using now _____ List medication allergies _____

List medications you are taking now _____

STAFF USE ONLY

HISTORY:

- | | |
|---|--|
| <input type="checkbox"/> Family history of clotting disorder | <input type="checkbox"/> ≥ 35 years of age and smokes |
| <input type="checkbox"/> Mother/father/sibling died of stroke/heart attack <50 yrs | <input type="checkbox"/> ≥ 35 years of age and migraine HA with or without aura |
| <input type="checkbox"/> Systemic Lupus erythematosus and positive or unknown antiphospholipid antibodies | <input type="checkbox"/> Major surgery with prolonged immobilization |
| <input type="checkbox"/> DVT/PE in legs, arms or lungs | <input type="checkbox"/> Bariatric surgery |
| <input type="checkbox"/> Known thrombogenic mutations | <input type="checkbox"/> Peripartum cardiomyopathy |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Breastfeeding |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Less than 21 days postpartum |
| <input type="checkbox"/> CVA or MI; vascular/ischemic heart disease/complicated vulvar heart disease | <input type="checkbox"/> Less than 42 days postpartum and risk factors for VTE: |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> ≥ 35 yo, <input type="checkbox"/> previous VTE, |
| <input type="checkbox"/> Active liver disease/ impaired liver function/liver tumors | <input type="checkbox"/> thrombophilia, <input type="checkbox"/> immobility, |
| <input type="checkbox"/> Current gallbladder disease | <input type="checkbox"/> transfusion at delivery, |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> BMI ≥ 30 , postpartum hemorrhage, |
| <input type="checkbox"/> Migraine HA with focal neurological symptoms | <input type="checkbox"/> post <input type="checkbox"/> C/S delivery, |
| | <input type="checkbox"/> preeclampsia, <input type="checkbox"/> smoking |
| | <input type="checkbox"/> Unprotected intercourse in last 5 day |

OBJECTIVE:

Blood Pressure: _____ Ht. _____ Wt. _____ BMI _____

Pregnancy Test: (circle) Pos Neg N/A

ASSESSMENT:

There (circle) ARE ARE NOT contraindications to starting estrogen containing hormonal contraceptives with an express visit.

There (circle) ARE ARE NOT contraindications to starting progestin containing hormonal contraceptives with an express visit.

PLAN:

The following contraceptive method was dispensed to the client with instructions for use:

Oral contraceptive: _____ # of cycles _____

NuvaRing: # Cycles _____ Ortho Evra: # Cycles _____

DMPA: 150 mg IM _____

Emergency contraception pills: Plan B _____ ella _____

Condoms dispensed _____

Family Planning appointment made for _____

Staff signature: _____ Date: _____

Provider name and title: _____ Date: _____